TRANSACTIONS

OF THE

NEW YORK SURGICAL SOCIETY.

Stated Meeting, October 12, 1904.

The President, HOWARD LILIENTHAL, M.D., in the Chair.

WOUND OF URETER DURING HYSTERECTOMY; ANASTOMOSIS; SUBSEQUENT NEPHRITIS; NEPHRECTOMY.

DR. F. TILDEN BROWN presented a single woman, forty years old, who was admitted to the Presbyterian Hospital on June 16, 1904. Her family history was negative. She had never had any children or miscarriages, and her previous history was good. Nine months ago her abdomen began to enlarge, without pain or other symptoms. This enlargement gradually continued. On July 21 a panhysterectomy was done for the removal of large fibroids of the uterus and broad ligaments, and during the operation the right ureter was divided. An immediate anastomosis was made, but a few days later urine began to discharge from the wound, and subsequently there was vesical irritability, with purulent urine, and at times involuntary micturition. The temperature ranged from 101° to 103° F. for two weeks, then from 100° to 101° F. until the fortieth day, when on July 30 it suddenly rose to 103° F. The patient complained of chilliness and pain in the right lumbar region. There was still some urinous discharge from the wound. The patient was weak and anæmic; the pulse was rapid and small, but regular. The right kidney was palpable and slightly enlarged; there was no tenderness; no rigidity. Leucocytes, 17,500. The urine contained pus and albumen and a few granular and hyaline casts. On August 2 the right kidney was exposed through a lumbar incision. It was found to be congested and partly adherent to its bed. After transfixing the pedicle, the

kidney was incised to allow the escape of blood and thus reduce its bulk, and was then excised. The stump of the ureter was cauterized after ligation. The opened fatty capsule was sutured to the transversalis fascia, and a cigarette drain inserted to base of wound. The patient made a rapid and steady improvement, and was discharged on the thirty-third day with a very small granulation at the lumbar scar and a small ventral superficial sinus. The pathological report was made by Dr. Tuttle, who stated that the kidney was much congested. There was slight round-celled infiltration and many casts.

TRAUMATIC RUPTURE OF URETER; EXTRAVASATION OF URINE; PYONEPHROSIS; NEPHRECTOMY.

DR. BROWN presented a boy, nine years old, who was admitted to the Presbyterian Hospital on July 2, 1904. His mother died of phthisis. The patient had always been delicate and had measles and diphtheria in infancy. Three weeks ago he was struck by a horse-car and caught under it, sustaining an injury to the left iliocostal region. He was not unconscious, but vomited frequently. On the day of his admission two ounces of urine were obtained by catheterization. The urine contained a trace of blood. The abrasion on the left side of the abdomen partly healed, but on the opposite side a tumefaction appeared, thought to be a hæmatoma. The patient was discharged from the hospital on June 26, apparently well. Since then he had been up and about, but complained of some pain in the right side, and the right side of his abdomen was increased in size. He still had occasional attacks of vomiting.

The patient was readmitted to the hospital on July 2. At this time he was anæmic and poorly nourished, and a systolic basal murmur was made out. The abdomen was prominent and bulging in the right flank, with dulness outward from the median line and dilated veins over the tumor, chiefly above the level of the umbilicus. Bimanually, a fluctuating tumor could be distinctly outlined just below the tip of the ninth cartilage, not moving with respiration. There was some tenderness over the mass. A rectal examination was negative. An X-ray picture of the trunk, the injection of tuberculin, and the transmitted light test were all negative. Temperature on admission, 99° F.; pulse, 96. Leucocyte count, 14,000. The urine was 1030; acid; no albumen, casts, nor blood cells. No tubercle bacilli.